Quality and Performance Improvement
Program Description
2017

Approved by CCHP Quality Council February 23, 2017
Introduction and Purpose

Contra Costa Health Plan (CCHP) is a federally qualified, state licensed, county sponsored Health Maintenance Organization serving Contra Costa County since 1973. We currently serve over 200,000 people. Contra Costa County is a primarily suburban county in the San Francisco Bay Area. As of 2010 there were roughly 1,050,000 residents. CCHP administers commercial products including one for County employees, Medi-Cal, and a Medicare Cost Plan. The majority of the business is centered around its Medicaid (Medi-Cal) product operations. The CCHP provider network consists of Contra Costa Regional Medical Center and Health Centers and contracted community providers and facilities. Kaiser Permanente network is a member option for Medi-Cal members with a recent personal or family history with Kaiser. The Plan’s contracts with participating practitioners and facilities specifically indicate that the practitioner/provider will cooperate with our Quality Program. This allows us access to clinical information pertaining to members, in accordance with the state and federal regulations, in order to collect appropriate data for monitoring and evaluation. This document provides information on the work of the health plan’s Quality functions. The Quality Program serves to facilitate safe, effective, efficient, and economical delivery of services throughout CCHP and its networks. It provides a structure to monitor the quality of clinical care and of service, to prioritize opportunities for improvement, to recommend improvement activities, and to track such activities to ensure resolution.

Program Objectives and Scope

The Quality Program strives to steadily improve the measures of quality and satisfaction year over year and to make more dramatic improvements to measures prioritized and assigned resources, such as through a Performance Improvement Project (PIP). The program tracks issues of quality of care, quality of service, and satisfaction and identifies and prioritizes opportunities for improvement. Tracking and improvement occurs in all three provider networks; we work collaboratively on improvement with the County health center system and with the Community-based clinics. The program ensures that all regulatory and contractual obligations related to quality and service are met. The program has taken on the leadership role for the organization-wide priority of Health Plan Accreditation by NCQA. We were initially granted three year Accreditation in March 2014. We were reaudited and granted another three year Accreditation in early 2017.

Program Structure

The Quality Improvement Program is provided oversight by the plan’s executive management, Quality Council, Clinical Leadership Group, the Managed Care Commission, and the Joint Conference Committee of the Contra Costa County Board of
Supervisors. The Joint Conference Committee has been delegated the oversight of the Plan by the County Board of Supervisors.

Our governing body, the Joint Conference Committee, gives authority to the Medical Director and the Chief Executive Officer of the Plan to ensure the Quality program has the needed resources to meet its goals and to evaluate the program's progress toward goals.

The CEO has authority over general administration of the Plan and reports to the JCC on the conduct of operations. The Medical Director provides operational oversight of the daily management of the overall Quality program, which is executed by the Quality Director and the Quality Department staff who report to him. The Director of Operations provides the daily management of all service related quality activities. The Provider Relations Director provides the daily management of all credentialing activities. The Director of Pharmacy provides the daily management of all pharmacy related quality and utilization activities. The UM Director provides daily management of the UM and Prior Authorization functions. The Case Management Director provides daily management of Case Management and Care Coordination activities. Various committees (described below) provide oversight to various components of clinical and service quality. These all report through the Quality Council, which in turn reports to the Joint Conference Committee.
Delegation

Some Plan functions are delegated to other organizations. For example, Kaiser is broadly responsible for the members we assign to them. We delegate some or all of these elements to Kaiser and CCRMC: Quality, including clinical guidelines and disease management, UM, grievance processing, credentialing, and Health Education. UM delegation to CCRMC was terminated February 1, 2017. Other groups, such as John Muir Physician Network are delegated for Credentialing only. We audit each delegated organization annually using tools based on NCQA standards and report findings to the Quality Council. As of 2015, the State and NCQA no longer require us to perform delegation audits on Kaiser for areas covered by NCQA Accreditation, due to their NCQA Accreditation. We continue oversight through review of data and quarterly meeting with Kaiser leadership, as well as auditing areas not covered by Accreditation. In addition, we review and approve Kaiser’s Quality and UM programs at appropriate committees. Refer to policy QM14.301 and to the individual delegation agreements for details.

Collaboration

CCHP participates in collaborative improvement efforts with the CCRMC system (County hospital and health centers) and with Community Provider Network providers. Current collaborations with CCRMC include the High Utilizers team to reduce readmissions, provide safer transitions of care, and identify and support patients at high risk. We are also collaborating to improve provision of behavioral health services, including embedding such services in physical health clinics. We also participate in the redesign of ambulatory care delivery and improvement of access to care. We also participate in their Lean model improvement events focused on patient safety and care redesign. We are collaborating also with CCRMC on improving PRIME measures (Medi-Cal waiver). We are collaborating with all of Contra Costa Health Services in CoCo 2020—working together to provide the best care and service to all we serve.

We collaborate with the Community Provider Network on reducing readmissions, improving perinatal care, improving diabetes care and increasing access to care. We are also encouraging our provider partners to become Recognized by NCQA as Patient-Centered Medical Homes by offering our expertise in working with NCQA and financial support toward applying for the Recognition.

The Quality Director and others report to Clinical Leadership Group and Quality Council about these activities.
Quality Management Staff and Resources

The work of the department is overseen by the Quality Management Director and carried out by two Registered Nurses, two Senior Health Education Specialists (one fluent in Spanish), three Project Managers, a Quality Analyst, and one Secretary. Additional Quality Nurses are available as needed on a per diem basis. We are currently trying to fill a position to manage Accreditation and Compliance, and we are considering an additional nurse to enhance the Disease Management Program. The department receives direction from CCHP’s Medical Director and consultation and guidance from five Medical Consultants. The Medical Consultants are Board Certified in their areas of expertise: three in Family Medicine, one in Pediatrics, and one in Psychiatry. The Medical Director chairs the Quality Council; the Medical Consultants are voting members. The Medical Director and Medical Consultants make decisions on grievances and appeals and provide consultation and direction on the selection and operation of Quality Improvement projects and other Quality Initiatives.

Most of the objectives in the Work Plan are executed by the departmental staff, but there is also collaboration across CCHP departments and with other areas of the county’s Health Services Division. These staff are found in Member Services, where they provide information to members and help solve problems including resolution on non-quality of care grievances, Case Management, which provides Complex Case Management services as well as a Transitions program to support continuity and continuation of medical care, Analysis and Reporting Unit, which provides reports and extracts data needed for more extensive analysis by the department, Utilization Management which tracks utilization metrics and ensures that appropriate services are authorized for members, and Provider Relations which maintains the Community Provider Network, ensures appropriate credentialing and recredentialing, performs Facility Site Reviews, and assists with educating providers and involving them in our improvement activities.

To support and ensure that staff can meet program responsibilities and goals, the following resources are made available: sufficient and ergonomic work space, necessary equipment and software, contracted services as required, funds for materials and publications, career development reimbursement, funds for member incentives for healthy practices, Print and Mail services, and temporary staff as necessary.
Medical Director and Medical Consultants

The Plan’s Medical Director has ultimate authority over the Quality Program. He or she provides program oversight through regular meeting with the Quality Director, through direct guidance of Quality Department staff as appropriate, by input and approval of all major reports and documents originating from Quality and Utilization Management, through chairing the Clinical Leadership Group and the Quality Council. The Medical Director provides guidance to the development of clinical guidelines, improvement projects, and other initiatives. The Medical Director makes determinations in grievances and appeals and has authority over peer review. The Program receives assistance and clinical direction from at least three Medical Consultants who have regularly scheduled hours in the Quality Department and who participate in the Clinical Leadership Group and Quality Council. At least one Consultant is Board certified in Pediatrics, at least one is Board certified in Family Medicine, and one is Board certified in Psychiatry.

Patient Safety

Patient safety is addressed by multiple Plan departments. Quality Program staff gather available data, stratify HEDIS measures, and monitor grievances and occurrences. Clinical guidelines are carefully reviewed and approved by the Medical Consultants and the Quality Council to ensure they are aligned with best practices. Provider Relations staff perform Facility Site Reviews and chart reviews and share the data with the Quality Program. Pharmaceutical safety is also addressed through abuse reporting, provider multiple prescribing of opiates, identification and sharing with Case Management of members on high numbers of medications, drug safety updates, member education materials on correct drug usage and adverse drug reaction identification. The Quality Department collects, researches, and evaluates Potential Quality Incidents, also called Occurrences, which are possible quality issues identified by staff or others. When problems are found, a corrective action plan is created and followed up on. In cases of more serious safety risks or when issues remain unresolved within a reasonable amount of time, the Medical Director may decide to remove a provider from our network. Safety issues are also addressed in our member and provider newsletters and other publications.
Behavioral Health

CCHP is responsible for mild to moderate mental health services for Medi-Cal and all mental/behavioral health services for commercial members. For Medi-Cal, CCHP partners with the Contra Costa County Mental Health Division to triage patients to determine level of severity and to provide treatment. For members who are seen at FQHCs in the community, members are triaged and treated at those facilities. Some County Health Centers are providing embedded behavioral health services. CCHP partnered with those clinics in several pilots to provide behavioral health care to patients receiving primary health care and primary care to patients receiving behavioral health care. Those services are now permanently established. They also now provide non-emergency drop in behavioral health care. Quality activities for behavioral health focus on HEDIS measures, continuity and coordination of care for outpatient behavioral health, pharmacy drug review, and behavioral health practitioner access and availability.

A Psychiatrist is one of our Medical Consultants. This provider advises the Quality and UM departments on behavioral health aspects of those programs. He or she also sits on the Quality Council to provide insight into behavioral health issues. Another Psychiatrist serves on the Pharmacy & Therapeutics Committee.

Objectives for Serving Members with Complex Health Needs

The Plan ensures members receive comprehensive high quality, well-coordinated care and service. The Complex Case Management program is focused on the delivery of cost-effective, appropriate health and social services for members with complex and chronic care needs. Proactive clinical and administrative processes are implemented to identify, coordinate, and evaluate appropriate services, which may be delivered on an ongoing basis. Case Management is performed through a process of telephonic assessment and review, and, as required, complemented with in-home visits. This program is directed at coordinating resources and creating individualized care plans to meet the member’s unique medical and psychosocial needs. These services are provided by our Case Management Department. Case Management also provides a Coleman Model Transitions Nurse who meets at-risk members while in the hospital, then visits them in their home and follows up via telephone. The purpose of this intervention is to make sure members transitioning from hospital to home have all the equipment, medications, and appointments they need. They also support a Nurse Practitioner who visits contracted Skilled Nursing Facilities to treat members there and to solve problems that would send them back to ER or inpatient care. Additionally, the Disease Management program provides education, coaching, tracking of gaps in care and alerting the member and their provider to the
gaps. That program helps get members into needed specialty care or classes and helps ensure adherence to treatment plan. Additionally, we provide information through Health Education, and the UM department performs concurrent review.

**Quality Management Governance**

The work of the QM Unit is reviewed and approved by CCHP executive management. QM Work Plan, Program Description, and Annual Program Evaluation receive approval from the Quality Council and our governing body, the Joint Conference Committee, which is chaired by a Board of Supervisors Member to provide oversight and appropriate review. The annual HEDIS report is also presented to those groups.

**Quality Council**

The Plan's Quality Council provides oversight to the Program. The members review and evaluate reports from the Quality function and other departments; they identify needed actions, recommend policy decisions, and ensure follow up as needed. The committee ensures that providers are involved in the planning and implementation of quality initiatives, as well as their review.

**Membership**

Medical Director, Chair
Quality Director, Co-chair
Chief Executive Officer
Director of UM and Auth
Case Management Director
Plan Pharmacy Manager
Providers from each care network (CCRMC, CPN, and Kaiser), including the Plan's Medical Consultants. There should be at least two certified in Family Medicine, two in Pediatrics, and one in Behavioral Health. In 2017, the specialties represented are Pediatrics (3), Family medicine (3), OB-GYN (1), and Behavioral Health (1).

Non-voting Members

Provider Relations Director
Chief Operating Officer
Member Services Manager

One or more representative of the Contra Costa Regional Medical Center and Health Centers’ Quality functions

The Council meets monthly, at least nine times per year. A quorum of half of the eligible voting members is required to make official decisions. It has responsibility to review and approve the reporting for the following committees and departments:

- Quality Department activities including: cultural and linguistic membership trends, linguistic needs and accessibility, multi-departmental health education projects and outreach, quality improvement reporting activities such as major regulatory reports, including the annual HEDIS report, and other results of quality measures, studies such as adherence to clinical guidelines, and projects such as Performance Improvement Projects (PIPs). The department also reports on activity and outcomes of the Disease Management Program, clinical quality grievances, and access to care, stratified by network. Reports on grievance rates and appeal rates are presented quarterly. Comprehensive member satisfaction results are presented annually through the thorough evaluation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and other satisfaction surveys, along with data from complaints and grievances. Annual delegation reports and quarterly data on the care networks, including oversight of Mental Health, are presented.

- Utilization Management: Annual program description and evaluation, major criteria or benefit changes, departmental metrics, and information on improvement efforts. (The Utilization Management Program and Evaluation documents are separate from the Quality Program documents.)
• Case Management: Reports on programs and updates on improvement projects. Updates on service, including number of members served.

• Pharmacy: Reports on service and costs; improvement projects or studies; formulary updates and other reporting on proceedings of Pharmacy and Therapeutics Committee. The Pharmacy Management program will assure pharmacy administration practices are aligned with DMHC, CMS, and NCQA regulations and standards.

• Advice Nurse Unit reports on quality of service: call answer data and satisfaction measures, and trends in call topics.

• Member Services presents tracking data on grievances and appeals and service quality data on the Member Call Center.

Additional QC Responsibilities:

- Requests for chartering of QI and PI projects or teams
- Discussion/approval of Clinical Guidelines
- Oversight of delegated entities, including review and approval of delegate QI programs and quarterly review of data.

The Quality Council also receives informational reports from the CEO and the Medical Director.

**Subcommittees Reporting to Quality Council**

The Appeals Committee manages both provider and member appeals. The committee reports a summary of the outcomes of its proceedings to the Council three times a year. Member appeals are part of the Member Services report, and provider appeals are part of the Provider Relations report. The Appeals Committee meets once a month or more often as needed. It is co-chaired by the manager of Provider Relations and Member Services. Other members include the Medical Director or physician designee, UM Director or Manager, Business Service Manager, Claims Supervisor, and Member Maintenance Unit Supervisor. In cases where a medical specialist opinion is needed, the specialist is a voting member. Please see the Appeals Committee Charter for further details.
Pharmacy and Therapeutics reports to QC quarterly. P&T Advisory committee meets at least quarterly to review pharmaceutical management. P&T keeps the Quality Council and provider networks abreast of drug utilization activities, fraud, waste and abuse, and all other issues of pharmacy management. P&T also reviews formulary changes, drug safety updates, recalls, pharmacy restriction and preference guidelines and generic substitution, therapeutic interchange and step therapy and other pharmaceutical management policies.

Credentialing Committee presents semi-annually to the QC summary data on the operation of the credentialing function, such as number of providers credentialed, recredentialed, or dropped. It submits the detailed information and recommendations directly to the Board of Supervisors. See committee charter for detailed information.

UM Committee reports to QC as part of the quarterly UM/Auth report. This committee oversees all Utilization Management, Utilization Review and Referral/Authorization policies and practices for the plan. Membership includes UM Director, Medical Director and consultants, including one from the Community Provider network, UM staff as assigned, Case Management Director, Quality Director, Claims Supervisor, and the Medical Director and the Administrator of UM at Contra Costa Regional Medical Center. The committee meets every two months.

CCHP/BH Meeting, formerly Alternative Mental Health Meeting: Access Line Manager reports quarterly. Additional information is provided in the CEO Report or Medical Director report.

**Clinical Leadership Group**

The CLG consists of the Medical Director, the Medical Consultants, a provider representative from the Community Provider Network, the Director of Utilization Management, and the Quality Director. Others are invited as required. The group serves to advise the Quality Director, solve problems in care delivery, and provide recommendations to the Quality Council. The group provides input on matters related to clinical practices, such as policies, clinical guidelines, improvement projects, and other clinical quality programs. For minor matters, such as approval of policies or guidelines with minimal updates, CLG can approve on Quality Council’s behalf, as long as such activities are reported to QC to ensure there are no objections. The group meets monthly, at least nine times a year.
Functions and Strategies

The overall functions of the Quality Program are:

Performance Measurement: Basing our prioritization of activity on high quality data helps ensure that the program is as effective and efficient as possible. Calculation of HEDIS (Health Effectiveness Data and Information Set) measures is essential to meeting contractual requirements with federal, state, and county entities and allows us to benchmark against other plans to identify opportunities to improve. Similarly, collection and analysis of stakeholder satisfaction allows us to prioritize opportunities for improvement.

Quality Improvement: Based on priorities determined by data analysis and other methods, we apply a variety of established improvement methodologies and tools to improve the well-being and satisfaction of those we serve and to improve the internal working of the health plan. Two of our projects are PIPs (Performance Improvement Projects) required by the State. In 2017, these are Improving Postpartum Care and Asthma Care. The Postpartum PIP will sunset in the third quarter; hypertension has been suggested as the next topic. Other improvement projects are our own initiatives or collaborations with other organizations or County entities.

Accreditation: The QM Program takes the lead on interpreting standards, identifying gaps, consulting with other functions on closing their gaps, ensuring submission of appropriate and timely documentation, and providing general oversight and maintenance of the NCQA accreditation status.

Cultural and Linguistic Services: Health Services Leadership emphasizes the importance of appropriately serving our culturally and linguistically diverse membership. Our program is frequently recognized as being at the forefront of these services. We ensure that CCHP members are aware of and have access to linguistic services necessary for them to communicate when receiving health care services. We are assisting the County with implementing the concepts we created in the area of REaL (Race, Ethnicity and Language) data collection thus ensuring they meet their own evolving regulatory requirements and provide improved service to those served. These services are essential to our work on reducing health disparities and to ensuring that all of the population served receives appropriate, effective care and a more satisfying experience. We also provide training to CCHP staff and contracted providers on cultural awareness and sensitivity. In 2017, C&L staff will assist in the Health Services-wide implementation of SO/GI (sexual orientation/gender identity) data.

The goals of our CLS program are:
• To prevent discrimination and to provide culturally sensitive and appropriate care to all CCHP members including beneficiaries with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. To provide oversight of cultural and linguistic services provided by contracted providers at CCRMC, Kaiser, and CPN
• To educate members, providers and employees about the importance of language services, cultural humility, health disparities, and their impact on health outcomes
• To assist providers in the delivery of culturally competent health care services
• To promote cultural competency/humility within CCHP in order to offer respectful and sensitive services to members
• To work with county health services department and community agencies to address the reduction of health disparities
• To be accountable and responsive to the needs of both our providers and our members for cultural and linguistic services and resources

Health Education: This program provides current educational materials for persons served by CCHP and reviews and promotes evidence-based materials and curricula for providers and staff members. We are making these available through electronic means where possible, while continuing to provide paper versions where necessary. Our program ensures that we meet all contractual, regulatory, and accreditation requirements in this area. At the end of 2015, we added a Health Risk Assessment that adult Medi-Cal members can take online (or by others means as necessary, assisted by the Health Educator) to identify health risks and to provide them with information and tools to improve their own health.

Health Outreach/Disease Management: These activities provide further education and support to members with certain conditions, including one to one nurse counseling for prioritized populations. The diseases targeted are prioritized by factors such as severity, numbers of members affected, and the existence of any disparities in process or outcome. In 2017, the program will continue providing services to adults with Diabetes and to obese children and their families. We will continue the program started in 2015 providing reminders for needed services and missed services. In coordination with CCRMC, we are piloting a birthday letter that informs members of their overdue health maintenance items. This project will be fully implemented in 2017.

Service Excellence: The Quality Management Department strives to exemplify the County’s Service Excellence philosophy in all of our internal and external interactions. Our specific responsibility of responding to clinical care grievances falls under this topic. We make every attempt to meet all regulatory requirements of the grievance process, including timeliness, and provide equitable
and caring decisions to members, while protecting plan resources for all we serve. We show respect for members’ grievances by studying trends and finding opportunities to improve. We enter 2017 with an improved system for collecting and tracking Potential Quality Incidents (PQIs) and Occurrences. A new report on them will be debuted this year.

Additional service issues tracked (some described in other sections) include call answer data from the Member Service and Advice Nurse call centers, CAHPS and other survey results, access to care, and availability of services.

Patient Safety
Staff regularly review data from grievances and appeals, PQIs and Occurrences, access and availability data, HEDIS measures, survey results, Utilization and Case Management data, studies on adherence to clinical guidelines, and data from Facility Site Reviews to identify areas of risk to members’ safety. Several programs are in place to improve safety, including the Disease Management Program, the Complex Case Management Program, the Postpartum Care and Asthma Improvement Projects (PIPs), the High Acuity Program, and the Care Transitions program. In 2017, we will be starting an additional Performance Improvement Project, likely targeting hypertension.

General Program Management: To provide the county and plan members with the kind of Quality Management Program they have a right to expect, we must support a culture of continuous improvement. Staff receive training and development. Program is evaluated to ensure it has the necessary resources to fulfill its responsibilities. The specific goals and the necessary actions to achieve the strategies behind these functions are detailed in the Work Plan. This document is created annually and updated throughout the year to reflect changes in direction and to track completion of tasks.

Additional quality management work is conducted by other departments. See the annual Case Management and UM reports for details.

Refer to the QI Work Plan for more details about activities planned, tracked, and assessed throughout the year. See also the Annual Evaluation of the prior year for trended measures, evaluation of effectiveness of the program, and descriptions of activities and barriers.